General

Guideline Title

Older people with social care needs and multiple long-term conditions.

Bibliographic Source(s)

National Institute for Health and Care Excellence (NICE). Older people with social care needs and multiple long-term conditions. London (UK): National Institute for Health and Care Excellence (NICE); 2015 Nov 4. 24 p. (NICE guideline; no. 22).

Guideline Status

This is the current release of the guideline.

This guideline meets NGC's 2013 (revised) inclusion criteria.

Recommendations

Major Recommendations

Note from the National Guideline Clearinghouse (NGC): See the "Availability of Companion Documents" field for the full version of this guidance and related appendices.

The wording used in the recommendations in this guideline (for example, words such as 'offer' and 'consider') denotes the certainty with which the recommendation is made (the strength of the recommendation) and is defined at the end of the "Major Recommendations" field.

Identifying and Assessing Social Care Needs

Health and social care practitioners should consider referring older people with multiple long-term conditions to the local authority for a needs assessment as soon as it is identified that they may need social care and support.

Consider referral for a specialist clinical assessment by a geriatrician or old-age psychiatrist to guide social care planning for older people with social care needs and multiple long-term conditions:

- Whose social care needs are likely to increase to the point where they are assessed as having a significant impact on the person's wellbeing
- Who may need to go into a nursing or care home

When planning and undertaking assessments for older people with social care needs and multiple long-term conditions, health and social care practitioners should:

- Always involve the person and, if appropriate, their carer

- Take into account the person's strengths, needs and preferences
- Involve the relevant practitioners to address all of the person's needs, including their medical, psychological, emotional, social, personal, sexual, spiritual and cultural needs; sight, hearing and communication needs; and accommodation and environmental care needs
- Ensure that if a person and their carer cannot attend an assessment meeting, they have the opportunity to be involved in another way, for example in a separate meeting or through an advocate (This is in addition to the statutory requirements placed on local authorities in relation to advocacy provision, set out in the Care Act 2014 .)
- Give people information about the services available to them, their cost and how they can be paid for

Recognise that many carers of older people with social care needs and multiple long-term conditions will also need support. If the person's carer has specific social care needs of their own, refer them to the local authority for a needs assessment in their own right.

Recognise that many older people with social care needs and multiple long-term conditions are also carers, but may not see themselves as such. Ask the person if they have caring responsibilities and, if so, ensure they are offered a carer's assessment.

Telecare to Support Older People With Social Care Needs and Multiple Long-term Conditions

The health or social care practitioner leading the assessment should discuss with the person any telecare options that may support them so that they can make informed choices about their usefulness to help them manage their conditions, as well as other potential benefits, risks and costs.

The lead practitioner should consider, in discussion with the person, whether a demonstration of telecare equipment would help them to make an informed decision about it.

Care Planning

Coordinating Care

Ensure that older people with social care needs and multiple long-term conditions have a single, named care coordinator who acts as their first point of contact. Working within local arrangements, the named care coordinator should:

- Play a lead role in the assessment process
- Liaise and work with all health and social care services, including those provided by the voluntary and community sector
- Ensure referrals are made and are actioned appropriately

Offer the person the opportunity to:

- Be involved in planning their care and support
- Have a summary of their life story included in their care plan
- Prioritise the support they need, recognising that people want to do different things with their lives at different times, and that the way that people's long-term conditions affect them can change over time

Ensure the person, their carers or advocate and the care practitioners jointly own the care plan, sign it to indicate they agree with it and are given a copy.

Review and update care plans regularly and at least annually (in line with the Care Act 2014) to recognise the changing needs associated with multiple long-term conditions. Record the results of the review in the care plan, along with any changes made.

Planning Care Collaboratively

Ensure care plans are tailored to each person, giving them choice and control and recognising the inter-related nature of multiple long-term conditions. Offer the person the opportunity to:

- Address a range of needs including medical, psychological, emotional, social, personal, sexual, spiritual and cultural needs, sight, hearing and communication needs and environmental care needs
- Address palliative and end-of-life needs
- Identify health problems, including continence needs and chronic pain and skin integrity, if appropriate, and the support needed to minimise their impact
- Identify the help they need to look after their own care and support, manage their conditions, take part in preferred activities, hobbies and interests, and make contact with relevant support services
- Include leisure and social activities outside and inside the home, mobility and transport needs, adaptations to the home and any support needed to use them

Discuss managing medicines with each person and their carer as part of care planning.

Write any requirements about managing medicines into the care plan including:

- The purpose of, and information on, medicines
- The importance of dosage and timing and implications of non-adherence
- Details of who to contact in the case of any concerns

For more information on managing medicines see the NGC summary of the NICE guideline Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes and the NICE guideline on managing medicines in care homes .

Develop care plans in collaboration with general practitioners (GPs) and representatives from other agencies that will be providing support to the person in the care planning process.

With the person's agreement, involve their carers or advocate in the planning process. Recognise that carers are important partners in supporting older people with social care needs and multiple long-term conditions.

Ensure older people with social care needs and multiple long-term conditions are supported to make use of personal budgets, continuing healthcare budgets, individual service funds and direct payments (where they wish to) by:

- Giving them and their carers information about different funding mechanisms they could use to manage the budget available to them, and any impact these may have on their carer
- Supporting them to try out different mechanisms for managing their budget
- Offering information, advice and support to people who pay for or arrange their own care, as well as to those whose care is publicly funded
- Offering information about benefits entitlement
- Ensuring that carers' needs are taken fully into account

Ensure that care plans enable older people with social care needs and multiple long-term conditions to participate in different aspects of daily life, as appropriate, including:

- Self-care
- Taking medicines
- Learning
- Volunteering
- Maintaining a home
- Financial management
- Employment
- Socialising with friends
- Hobbies and interests

Ensure that care plans include ordinary activities outside the home (whether that is a care home or the person's own home), for example shopping or visiting public spaces. Include activities that:

- Reduce isolation because this can be particularly acute for older people with social care needs and multiple long-term conditions
- Build people's confidence by involving them in their wider community, as well as with family and friends

Supporting Carers

In line with the Care Act 2014 local authorities must offer carers an individual assessment of their needs. Ensure this assessment:

- Recognises the complex nature of multiple long-term conditions and their impact on people's wellbeing
- Takes into account carers' views about services that could help them maintain their caring role and live the life they choose
- Involves cross-checking any assumptions the person has made about the support their carer will provide.

Check what impact the carer's assessment is likely to have on the person's care plan.

Support carers to explore the possible benefits of personal budgets and direct payments, and how they might be used for themselves and for the person they care for. Offer the carer help to administer their budget so that their ability to support the person's care or their own health problems are not undermined by anxiety about managing the process.

Consider helping carers access support services and interventions, such as carer breaks.

Integrating Health and Social Care Planning

Build into service specifications and contracts the need:

- To direct older people with social care needs and multiple long-term conditions to different services as needed
- For seamless referrals between practitioners, including the appropriate sharing of information
- To make links with appropriate professionals, for example geriatricians in acute care settings

Ensure there is community-based multidisciplinary support for older people with social care needs and multiple long-term conditions, recognising the progressive nature of many conditions. The health and social care practitioners involved in the team might include, for example, a community pharmacist, physiotherapist or occupational therapist, a mental health social worker or psychiatrist, and a community-based services liaison worker.

Health and social care practitioners should inform the named care coordinator if the person has needs that they cannot meet.

Named care coordinators should record any needs the person has that health and social care practitioners cannot meet. Discuss and agree a plan of action to address these needs with the person and their carer.

Delivering Care

Providing Support and Information

Health and social care providers should ensure that care is person-centred and that the person is supported in a way that is respectful and promotes dignity and trust.

Named care coordinators should review people's information needs regularly, recognising that people with existing conditions may not take in information when they receive a new diagnosis.

Consider continuing to offer information and support to people and their carers even if they have declined it previously, recognising that long-term conditions can be changeable or progressive, and people's information needs may change.

Inform people about, and direct them to, advocacy services.

Health and social care practitioners should offer older people with social care needs and multiple long-term conditions:

- Opportunities to interact with other people with similar conditions
- Help to access one-to-one or group support, social media and other activities, such as dementia cafés, walking groups and specialist support groups, exercise and dance

Supporting Self-management

Health and social care practitioners should review recorded information about medicines and therapies regularly and follow up any issues related to managing medicines. This includes making sure information on changes to medicines is made available to relevant agencies.

Social care practitioners should contact the person's healthcare practitioners with any concerns about prescribed medicines.

Social care practitioners should tell the named care coordinator if any prescribed medicines are affecting the person's wellbeing. This could include known side effects or reluctance to take medicines.

Health and social care providers should recognise incontinence as a symptom and ensure people have access to diagnosis and treatment. This should include meeting with a specialist continence nurse.

Health and social care providers should give people information and advice about continence. Make a range of continence products available, paying full attention to people's dignity and treating them with respect.

Health and social care providers should give people information about services that can help them manage their lives. This should be given:

- At the first point of contact and when new problems or issues arise
- In different formats which should be accessible, including through interpreters

Ensuring Continuity of Care and Links with Specialist Services

Named care coordinators should take responsibility for:

- Giving people and their carers information about what to do and who to contact in times of crisis, at any time of day or night
- Ensuring an effective response in times of crisis
- Ensuring there is continuity of care with familiar workers, so that wherever possible, personal care and support is carried out by workers known to the person and their family and carers
- Engaging local community health and social care services, including those in the voluntary sector
- Ensuring people and their carers have information about their particular conditions, and how to manage them
- Knowing where to access specialist knowledge and support, about particular health conditions
- Involving carers and advocates

Care in Care Homes

These recommendations for care home providers are about ensuring that care and support addresses the specific needs of older people with social care needs and multiple long-term conditions in care homes. (See the NICE quality standard on Mental wellbeing of older people in care homes . For recommendations about delivering care at home, see the NICE guideline on home care .)

Identify ways to address particular nutritional and hydration requirements.

Ensure people have a choice of things to eat and drink and varied snacks throughout the day, including outside regular meal times.

Ensure the care home environment and layout are used in a way that encourages social interaction, activity and peer support, as well as providing privacy and personal space.

Ensure people are physically comfortable, for example by allowing them control over the heating in their rooms.

Encourage social contact and provide opportunities for education, entertainment and meaningful occupation by:

- Making it easier for people to communicate and interact with others, for example by reducing background noise, providing face-to-face contact with other people, using accessible signage and lighting
- Using a range of technologies such as IT platforms and Wi-Fi, hearing loops and TV listeners
- Involving the wider community in the life of the care home through befriending schemes and intergenerational projects
- Offering opportunities for movement

Build links with local communities, including voluntary and community sector organisations that can support older people with social care needs and multiple long-term conditions, and encourage interaction between residents and local people of all ages and backgrounds.

Make publicly available information about:

- Tariffs for self-funded and publicly-funded care
- What residents are entitled to and whether this could change if their funding status or ability to pay changes

Make available a statement for each person using services about what their funding pays for.

Preventing Social Isolation

All practitioners should recognise that social isolation can be a particular problem for older people with social care needs and multiple long-term conditions.

Health and social care practitioners should support older people with social care needs and multiple long-term conditions to maintain links with their friends, family and community, and identify if people are lonely or isolated.

Named care coordinators and advocates should provide information to help people who are going to live in a care home to choose the right care home for them, for example one where they have friends or links with the community already.

Health and social care practitioners should give people advice and information about social activities and opportunities that can help them maintain their social contacts, and build new contacts if they wish to.

Consider contracting with voluntary and community sector enterprises and services to help older people with social care needs and multiple long-

term conditions to remain active in their home and engaged in their community, including when people are in care homes.

Voluntary and community sector providers should consider collaborating with local authorities to develop new ways to help people to remain active and engaged in their communities, including when people are in care homes.

Training Health and Social Care Practitioners

Those responsible for contracting and providing care services should ensure health and social care practitioners caring for older people with social care needs and multiple long-term conditions are assessed as having the necessary training and competencies in managing medicines.

Ensure health and social care practitioners are able to recognise, consider the impact of, and respond to:

- Common conditions, such as dementia, hearing and sight loss, and
- Common care needs, such as nutrition, hydration, chronic pain, falls and skin integrity, and
- Common support needs, such as dealing with bereavement and end-of-life, and
- Deterioration in someone's health or circumstances (this recommendation is adapted from NICE's guideline on home care)

Make provision for more specialist support to be available to people who need it – for example, in response to complex long-term health conditions – either by training practitioners directly involved in supporting people, or by ensuring partnerships are in place with specialist organisations.

Definitions

Recommendation Wording

The Guideline Committee makes recommendations based on an evaluation of the evidence, taking into account the quality of the evidence and cost-effectiveness.

In general, recommendations that an action 'must' or 'must not' be taken are usually included only if there is a legal duty (for example, to comply with the Care Act or health and safety regulations), or if the consequences of not following it could be extremely serious or life threatening.

Recommendations for actions that should (or should not) be taken use directive language such as 'agree', 'offer', 'assess', 'record' and 'ensure'.

Recommendations for which the quality of the evidence is poorer, or where there is a closer balance between benefits and risks, use 'consider'.

Clinical Algorithm(s)

A National Institute for Health and Care Excellence (NICE) pathway titled "Social care for older people with multiple long-term conditions overview" is available from the NICE Web site

Scope

Disease/Condition(s)

Long-term conditions which result in social care needs, including:

- Arthritis
- Asthma
- Cancer
- Dementia
- Diabetes
- Heart disease
- Mental health conditions
- Stroke

Guideline Category

Evaluation

Management

Clinical Specialty

Endocrinology

Family Practice

Geriatrics

Nursing

Intended Users

Advanced Practice Nurses

Allied Health Personnel

Health Care Providers

Hospitals

Nurses

Patients

Physician Assistants

Physicians

Psychologists/Non-physician Behavioral Health Clinicians

Public Health Departments

Social Workers

Guideline Objective(s)

- To consider how person-centred social care and support for older people with multiple long-term conditions should be planned and delivered
- To address how those responsible for commissioning, managing and providing care for people with multiple long-term conditions should work together to deliver safe, high-quality services that promote independence, choice and control

Target Population

Older people, aged 65 years and older, with multiple long-term conditions that use social care services, and their families, partners and carers

Interventions and Practices Considered

Assessment

1. Identification and assessment of social care needs
    - Referral to the local authority for a needs assessment

    - Referral for a specialist clinical assessment by a geriatrician or old-age psychiatrist
2. Telecare options
3. Assessment of carers needs

Management

1. Care planning
2. Planning care collaboratively
    - Development of care plans
    - Tailoring to each individual to provide choice and control
    - Collaboration with general practitioners (GPs) and representatives from other agencies
    - Involvement of carers or advocates in the planning process
    - Management of medicines
    - Inclusion of ordinary activities outside the home
3. Support for carers
4. Integration of health and social care planning: establishment of a community-based multidisciplinary support team (e.g. community pharmacist, physiotherapist or occupational therapist, a mental health social worker or psychiatrist, and a community-based services liaison worker)
5. Delivery of care
    - Provision of support and information (in a way that is respectful and promotes dignity and trust)
    - Support self-management
    - Ensure continuity of care and links with specialist services
    - Management of care of individuals in care homes
    - Prevention of social isolation
6. Training of health and social care practitioners

Major Outcomes Considered

- Prevention
- Delayed onset
- Progression rates
- Quality of life
- Positive experience related to independence, choice, dignity and control
- User satisfaction including quality and continuity of care
- Cost-effectiveness

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Note from the National Guideline Clearinghouse (NGC): See the "Availability of Companion Documents" field for the full version of this guidance and related appendices.

How the Literature Was Searched

The evidence reviews used to develop the guideline recommendations were underpinned by systematic literature searches. The aim of the systematic searches was to comprehensively identify the published evidence to answer the review questions developed by the Guideline Committee and the National Institute for Health and Care Excellence (NICE) Collaborating Centre for Social Care.

The search strategies for the review questions (based on the Scope) were developed by the NICE Collaborating Centre for Social Care in order to identify empirical research. The search strategies are listed in Appendix A.

Searches were based upon retrieving items for the population groups 'older people', 'carers', 'long-term conditions', 'workforce/social care organisation' in the settings of 'residential care', 'nursing/care homes', 'intermediate care' or 'community care'. Searches were developed using subject heading and free text terms, aiming to balance sensitivity and precision, and the strategy was run across a number of databases. The searches limited results to studies published from 2004 onwards. The database searches were not restricted to specific geographical areas; however, in selecting the Web sites to search, research on people's views was focused on the UK. The sources searched are listed below. Forward and backwards citation searches using Google Scholar were undertaken in January 2015 for all of the included studies.

The Guideline Committee members were also asked to alert the NICE Collaborating Centre for Social Care to any additional evidence, published, unpublished or in press, that met the inclusion criteria.

Full details of the search can be found in Appendix A.

How Studies Were Selected

Search outputs (title and abstract only) were stored in EPPI Reviewer 4 – a software programme developed for systematic review of large search outputs – and screened against an exclusion tool informed by the parameters of the scope. Formal exclusion criteria were developed and applied to each item in the search output, as follows

- Language (must be in English)
- Population (must be older people with multiple long-term conditions, with a social care need)
- Intervention (must be identification/assessment of social care needs; personalised care planning; support to self-manage; integration of social and healthcare; training of staff to recognise/manage common long-term conditions; support for carers to care; interventions to support involvement and participation, including information for users and carers
- Setting (must be in the person's home or care home)
- Workforce (must involve people who work in social care, who are integrated with social care or act as gatekeepers to social care)
- Country (must be UK, European Union, Denmark, Norway, Sweden, Canada, USA, Australia and New Zealand)
- Date (not published before 2004)
- Type of evidence (must be research)
- Relevance to (1 or more) review questions

Title and abstract of all research outputs were screened against these exclusion criteria. Those included at this stage were marked for relevance to particular review questions and retrieved as full texts.

Full texts were again reviewed for relevance and research design. If still included, critical appraisal (against NICE tools) and data extraction (against a coding set developed to reflect the review questions) was carried out. The coding was all conducted within EPPI Reviewer 4, and formed the basis of the analysis and evidence tables. All processes were quality assured by double coding of queries, and of a random sample of 10%.

In the initial screen (on title and abstract), the Guideline Committee found 75 studies which appeared relevant to the review questions. The authors ordered full texts of 23 papers, prioritising views and experiences studies from the UK, and those that were of acceptable methodological quality. On receiving and reviewing the full texts, they identified 11 which fulfilled these criteria. Of these, 4 were qualitative views research studies, and 7 were quantitative impact studies. The included studies were critically appraised using NICE tools for appraising different study types, and the results tabulated. Study findings were extracted into findings tables. For full critical appraisal and findings tables, see Appendix B in the full version of the guideline document.

See Appendix A for details of the search strategies, review questions and review protocols for the guideline.

Number of Source Documents

See Figure A1 in Appendix A (see the "Availability of Companion Documents" field) for a flow chart summarising included and excluded studies.

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Studies were rated for internal and external validity using ++/+/- (meaning very good, good to moderate, and poor). Where there are 2 ratings (for example +/-), the first rating applies to internal validity (how convincing the findings of the study are in relation to its methodology and conduct). The second rating concerns external validity (whether it is likely that the findings can be applied to similar contexts elsewhere).

Methods Used to Analyze the Evidence

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

Note from the National Guideline Clearinghouse (NGC): See the "Availability of Companion Documents" field for the full version of this guidance and related appendices.

Evidence Review and Recommendations

Given the complex and wide-ranging nature of the topic, many of the questions were necessarily broad. The Guideline Committee therefore specified in the protocols that a relatively broad range of study designs that were likely to be relevant to each question, with the exception of effectiveness questions which require studies to include a control group. Rating the included studies was complex as the 'best available' evidence was often only of moderate quality. Studies were rated for internal and external validity using ++/+/- (meaning very good, good to moderate, and poor). Where there are 2 ratings (for example +/-), the first rating applies to internal validity (how convincing the findings of the study are in relation to its methodology and conduct). The second rating concerns external validity (whether it is likely that the findings can be applied to similar contexts elsewhere). Qualitative evidence is (largely) only rated for internal validity, given that it is typically context-specific and generalisability is highly limited, and some surveys with a relatively high response rate within a well-defined population (for example, Department of Health, Social Services and Public Safety [DHSSPS] 2010, a survey of providers in Northern Ireland) may also have a single rating for internal validity if it is unclear how well the context matches the English context. Hence some studies have a single rating (for example, ++) and others have 2 ratings (for example, +/+).

The quality of economic evaluations is described on the basis of their limitations and therefore applicability in answering whether the intervention is cost-effective from the NHS and personal social services perspective, described as having very serious, potentially serious, or minor limitations, accompanied with further detail. Methodological appraisal detailing the limitations of these studies is fully described in Appendix C1.

The critical appraisal of each study takes into account methodological factors such as:

- Whether the method used is suitable to the aims of the study
- Whether random allocation (if used) was carried out competently
- Sample size and method of recruitment
- Whether samples are representative of the population we are interested in
- Transparency of reporting and limitations that are acknowledged by the research team

Evidence rated as of only moderate or poor quality may be included in evidence statements, and taken into account in recommendations, because the Guideline Committee independently and by consensus supported its conclusions and thought a recommendation was needed. In the evidence statements, evidence from more than 1 study rated as good and poor may be described as 'moderate'. Where evidence is described as 'very good', it suggests that several well-conducted studies support the same or similar conclusions.

For full critical appraisal and findings tables see Appendix B.

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Note from the National Guideline Clearinghouse (NGC): See the "Availability of Companion Documents" field for the full version of this guidance and related appendices.

Evidence Review and Recommendations

When this guideline was started, the authors used the methods and processes described in the Social Care Guidance Manual (2013). From January 2015 they used the methods and processes in Developing NICE Guidelines: The Manual (2014) (see the "Availability of Companion Documents" field). The included studies were critically appraised using tools in the manuals and the results tabulated. Minor amendments were made to some of the checklists to reflect the range of evidence and types of study design considered in the evidence reviews. Published evidence was identified by systematic searches of health, social care, social sciences and economic databases and organisations that produce empirical information. It was decided, with the Guideline Committee, to restrict the searches to studies published from 2004 onwards. This was to ensure that the number of outputs were manageable, while also being confident that important and relevant studies would be identified, and that retrieved evidence would be relevant to current practice. References submitted by Guideline Committee members and stakeholders were also considered.

As the main search was broad in nature and focused on the population of interest, rather than interventions, it was agreed with the Guideline Committee that, rather than re-running searches towards the end of the process, it was more appropriate to conduct forwards and backwards citation searching to identify evidence that cited the included references and backwards citation searching by scanning the reference lists of included studies for relevant articles that met the inclusion criteria. This was in order to maximise the relevance of the results, and is also standard practice in the production of systematic reviews. Web sites and organisations were manually searched in order to identify empirical evidence that is not indexed on databases, and forwards and backwards citation searching was also carried out.

During the development of the guideline, Guideline Committee members highlighted a need to strengthen the voice of older people within the guideline. Although groups representing this audience were registered as stakeholders, Guideline Committee members were keen to hear directly from individuals as part of the consultation stage. In order to access these views, a targeted consultation to test the draft recommendations directly with people using services was agreed, as outlined in the Manual. The targeted consultation was undertaken by the National Institute for Health and Care Excellence (NICE) Collaborating Centre for Social Care (NCCSC) in partnership with Age UK (Sutton) and Bradstow Court (an Extra Care Housing unit, part of the Housing and Care 21 group). The results of the targeted consultation were in line with consultation comments received at stakeholder consultation. As such, where any changes made to the recommendations are noted as being based on consultation responses, that includes the results of this targeted consultation. The report can be found in Appendix E.

Refer to the "Evidence to recommendations" section of the full version of the guideline for the details of the links between the recommendations, the evidence reviews, expert witness testimony and the Guideline Committee discussions. The information is presented in a series of linking evidence to recommendations (LETR) tables.

Rating Scheme for the Strength of the Recommendations

Recommendation Wording

The Guideline Committee makes recommendations based on an evaluation of the evidence, taking into account the quality of the evidence and cost-effectiveness.

In general, recommendations that an action 'must' or 'must not' be taken are usually included only if there is a legal duty (for example, to comply with the Care Act or health and safety regulations), or if the consequences of not following it could be extremely serious or life threatening.

Recommendations for actions that should (or should not) be taken use directive language such as 'agree', 'offer', 'assess', 'record' and 'ensure'.

Recommendations for which the quality of the evidence is poorer, or where there is a closer balance between benefits and risks, use 'consider'.

Cost Analysis

This report addresses the following review questions as set out in the guideline topic:

- Assessment and care planning: What are the effects (benefits and harms) of different types of assessment and planning of personalised care on outcomes for older people with multiple long-term conditions and their carers?
- Service delivery frameworks: What are the existing frameworks, models and components of care packages for managing multiple long-term conditions and what outcomes do they deliver?

Decision Problem

The intervention selected for the economic evaluation is the Counsell (2007) intervention, which is an American study, termed the 'GRACE' model of care (Geriatric Resources for Assessment and Care of Elders). The aim of the analysis presented is to assess whether the GRACE model might be cost-effective in the English context.

This analysis takes the perspective of the National Health System (NHS)-funded services as the study only reported on changes in healthcare resources. However, the intervention does comprise of a social care worker and the use of an occupational therapist and community services liaison, however whether this would be funded by personal social services or the NHS is unclear.

Rationale for the Chosen Economic Evaluation Approach

In this study, the Guideline Committee combine the results from cost-consequence and a cost-utility analyses. A cost-utility analysis is a type of cost-effectiveness analysis in which the unit of effect is measured in terms of a utility indicator (in this case the quality-adjusted life year - QALY). The cost-effectiveness of an intervention is then determined by examining the incremental cost ($C^I - C^C$) divided by the incremental effect ($E^I - E^C$), where C^I and C^C represent the cost of the intervention and control groups, respectively, and $E^I - E^C$ represent the outcomes of the intervention and control groups, respectively. The higher the incremental cost effectiveness ratio (ICER), the less cost-effective the intervention is found to be.

A cost-consequence analysis presents the incremental costs alongside incremental consequences for a number of outcome indicators. Consequences (outcomes) are broadly defined and can include utility measures and any other measures, for example health and social care related outcome indicators such as depression scores, social activity scores, etc.

Economic evaluation aims to help decision-makers allocate resources to interventions that provide the most value for money. When the ICER is less than £0 because the intervention delivers cost savings and delivers more benefit, the intervention is generally recommended. From the NICE clinical perspective, the acceptable maximum amount of money to be paid for an additional QALY is where the ICER is between £0 and £20,000 but advises more caution in concluding something is cost-effective where the ICER is between £20,000 and £30,000. When interventions are above £30,000 per QALY, interventions are generally seen as being not cost-effective, although this is not a strict rule and value judgements are needed.

Methods for Undertaking Cost-Utility Analysis

The non-UK interventions considered in the review might not be expected to yield the same results when applied in the English context because of:

- Differences between countries in the patterns of services use. For instance, a service which yields cost savings because it leads to reductions in the use of acute care services is less likely to be cost-effective in settings with very low 'standard' use of acute care, other things being equal
- Differences in the unit costs of services
- Differences in the implementation of the intervention, because, for instance, of differences in skills and technologies

Modelling analysis can be used to test the robustness of the published results to different assumptions about patterns of service use and service unit costs, and in doing so attempt to approximate the non-UK published results to the English service context. The steps undertaken to carry out this analysis are summarised below and further detail is provided in subsequent sections. The analysis was calculated using a Microsoft Excel spread sheet.

Refer to Appendix C3 (see the "Availability of Companion Documents" field) for further discussion of this economic model.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

The guideline was validated through two consultations.

1. The first draft of the guideline (the full guideline and National Institute for Health and Care Excellence [NICE] guideline) were consulted with Stakeholders and comments were considered by the Guideline Development Group (GDG).
2. The final consultation draft of the full guideline, the NICE guideline and the Information for the Public were submitted to stakeholders for final comments.

The final draft was submitted to the Guideline Review Panel for review prior to publication.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of evidence supporting the recommendations is not specifically stated.

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

- Multidisciplinary geriatric assessments, combined with appropriate interventions, could improve on clinical outcomes such as hospital admissions and reduced length of stay.
- In one study, client involvement, and opportunities to discuss the needs of elderly persons within a group of different professionals, was conducive to greater understanding of the potential of teamwork to deliver good outcomes.

Refer to the "Trade-off between benefits and harms" sections in the full version of the guideline (see the "Availability of Companion Documents" field) for benefits of specific interventions.

Potential Harms

- The Guideline Committee noted the potential benefits of telecare in terms of promoting people's independence but also cautioned that reduced contact (particularly if telecare is used as a substitute for face-to-face time) may be disadvantageous for the person. They also noted that many older people may have to fund their own telecare.
- The potential harms of conducting an assessment which does not take into account 'the whole person' may be that it results in a care plan which does not meet their needs.
- Known side effects or reluctance to take medicines

Refer to the "Trade-off between benefits and harms" sections in the full version of the guideline (see the "Availability of Companion Documents" field) for harms of specific interventions.

Qualifying Statements

Qualifying Statements

- This guideline assumes that the practitioners using it will read it alongside the Care Act 2014 and other relevant legislation and statutory guidance. It is also written to reflect the rights and responsibilities that people and practitioners have as set out in the National Health Service (NHS) Constitution for England.
- This guideline has been developed in the context of a complex and rapidly evolving landscape of guidance and legislation, most notably the Care Act 2014. While the Care Act and other legislation describe what organisations must do, this guideline is

focused on 'what works' in terms of how to fulfil those duties, and deliver support to older people with social care needs and multiple long-term conditions.
- See the "Person-centred care" section in the full version of the guideline (see the "Availability of Companion Documents" field).

Implementation of the Guideline

Description of Implementation Strategy

Implementation: Getting Started

This section highlights 3 areas of the older people with social care needs and multiple long-term conditions guideline that could have a big impact on practice and be challenging to implement, along with the reasons why change is happening in these areas. The section also gives information on resources to help with implementation.

The Challenge: Empowering Older People with Social Care Needs and Multiple Long-term Conditions and Their Carers to Choose and Manage Their Own Support

A person-centred assessment, focused on ensuring a person has choice and control over their care and support, can:

- Result in a care and support plan that better meets the person's needs, helps them to maintain their independence for longer and may delay the need for higher levels of care
- Contribute to the person's sense of wellbeing and improve their quality of life, which is consistent with the principles of the Care Act 2014 and the desire of older people to live a 'normal' life as described in published research

Changing Perceptions

As a result of pressures within the social care system, managers and practitioners often prioritise meeting older peoples' essential personal care needs over their wish to live a 'normal' life. This approach needs to change to reflect a much wider understanding of the role and contribution of social care.

To do this, social care managers and practitioners could:

- Work in partnership with focus groups, care providers or existing local forums to review their provision of information and advice, and ensure it covers all aspects needed to enable people to choose and manage their own care and support. The Care Act Statutory Guidance provides some helpful points to consider. The Social Care Institute for Excellence (SCIE) guide on co-production in social care provides some helpful pointers and practice examples about reviewing services in partnership with those who use them.
- Draw on information and examples, such as those found in SCIE's Prevention Library or as part of the Campaign to End Loneliness, to develop an awareness and understanding of the impact of social isolation. They should also consider the contribution that person-centred assessment and support planning can make to reduce social isolation, including through access-to-peer support.
- Work with older people locally who are already using personal budgets, continuing healthcare budgets, individual service funds and direct payments, to review the support they need

The Challenge: Empowering Practitioners to Deliver Person-centred Care

Knowledgeable, confident and well-supported practitioners can deliver:

- More effective person-centred care and support that promotes independence, choice and control for older people with multiple long-term conditions using health and social care services
- Coordinated care that is more cost-effective and better meets the wishes of older people as highlighted in the National Voices publication 'I'm still me' – a narrative for coordinated support for older people

Skills and Knowledge Development

To support older people with social care needs and multiple long-term conditions, health and social care practitioners need to have skills and

knowledge about a range of conditions, care needs, support options and legislation. Managers also need to understand their role in supporting this.

To do this, managers could:

- Use this guideline and local forums to review the knowledge, skills and qualifications practitioners need to provide person-centred care and support to older people with social care needs and multiple long-term conditions, and to identify any gaps
- Use resources (such as the SCIE guide to effective supervision in a variety of settings) that highlight the importance of supervision, coaching, training and development plans, and regularly review progress and performance in partnership with practitioners
- Use the Care Quality Commission's provider handbook (Appendix B: Characteristics of each rating level) to understand the characteristics of a well-led service and review the current approach using this as a benchmark
- Use resources such as those developed by Skills for Care to review and identify the personal support managers need, including from their peers, to provide effective and supportive management and leadership

The Challenge: Integrating Different Care and Support Options to Enable Person-centred Care

Joined-up care and support helps to deliver better experiences and outcomes for older people with social care needs and multiple long-term conditions and their carers, who are known to value coordinated care with good links to the wider health and social care system. It also saves time and money across the health and social care system through avoiding duplication.

Working Across Boundaries

Traditionally, health and social care services that support older people with social care needs and multiple long-term conditions focus on managing separate health conditions, and the system is complex to navigate. Systems and structures may need to change to help professionals to work athwart service boundaries and specialisms.

To do this, managers and commissioners could:

- Establish named care coordinators locally and ensure they have the authority to provide continuity of support and amend care and support plans as needed. Share information about their role and responsibilities widely to make sure it is fully understood.
- Provide care coordinators with the necessary training and support based on a clear understanding of their role, and the skills and knowledge they need
- Review local relationships across health, social care and the voluntary sector and identify where more support is needed to work across service boundaries and professions. Resources such as the How to… guides produced to support the Better Care Fund can help with this.

Implementation Tools

Clinical Algorithm

Mobile Device Resources

Patient Resources

Resources

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

End of Life Care

Living with Illness

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

National Institute for Health and Care Excellence (NICE). Older people with social care needs and multiple long-term conditions. London (UK): National Institute for Health and Care Excellence (NICE); 2015 Nov 4. 24 p. (NICE guideline; no. 22).

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2015 Nov 4

Guideline Developer(s)

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Guideline Committee

Guideline Committee

Composition of Group That Authored the Guideline

Not stated

Financial Disclosures/Conflicts of Interest

Not stated

Guideline Status

This is the current release of the guideline.

This guideline meets NGC's 2013 (revised) inclusion criteria.

Guideline Availability

Available from the National Institute for Health and Care Excellence (NICE) Web site. Also available in ePub or eBook formats from the NICE Web site.

Availability of Companion Documents

The following are available:

- Older people with social care needs and multiple long-term conditions. Full guideline. London (UK): National Institute for Health and Care Excellence (NICE); 2015 Oct. 166 p. (NICE guideline; no. 22). Available from the National Institute for Health and Care Excellence (NICE) Web site.
- Older people with social care needs and multiple long-term conditions. Appendices. London (UK): National Institute for Health and Care Excellence (NICE); 2015 Nov 4. (NICE guideline; no. 22). Available from the NICE Web site.
- Older people with social care needs and multiple long-term conditions. Costing report. London (UK): National Institute for Health and Care Excellence (NICE); 2015 Nov 3. 14 p. (NICE guideline; no. 22). Available from the NICE Web site.
- Older people with social care needs and multiple long-term conditions. Baseline assessment tool. London (UK): National Institute for Health and Care Excellence (NICE); 2015 Nov 4. (NICE guideline; no. 22). Available from the NICE Web site.
- The social care guidance manual. London (UK): National Institute for Health and Care Excellence (NICE); 2013 Apr. Available from the NICE Web site.
- Developing NICE guidelines: the manual. London (UK): National Institute for Health and Care Excellence (NICE); 2014 Oct. Available from the NICE Web site.

Patient Resources

The following is available:

- Older people with social care needs and multiple long-term conditions. Information for the public. London (UK): National Institute for Health and Care Excellence (NICE); 2015 Nov 4. 5 p. (NICE guideline; no. 22). Available from the National Institute for Health and Care Excellence (NICE) Web site. Also available in ePub or eBook formats from the NICE Web site.

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

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